FIRST STEPS COST PARTICIPATION CO-PAYMENT FORM

State Form 51361 (R / 4-06) / BCD 0092
Division of Disability and Rehabilitative Services

First Steps

Effective May 01, 2006

The information contained in this form is to be generated by the SPOE computer. This form may be used as a worksheet or in the event the SPOE computer is unable to generate the electronic version prior to the IFSP meeting.

Name of child	Date of birth (*month, day, year*)	First Steps ID
Name of parent / guardian		

Determination of annual income must be made once the Intake/SC and parent review both the annual income and potential expenses.

Annual Gross Income (*prior to any allowable expenses*) $ _____

Total Expenses (*as documented on the First Steps expenses worksheet*) $ _____

Annual Adjusted Income (*Annual Gross Income minus any medical or personal care needs expenses as documented on the First Steps expenses worksheet*) $ _____

SPOE USE ONLY - FEE FOR SERVICE OPTION

Based on income and expense information provided by the parents and as documented on Cost Participation verification form and First Steps Expenses worksheet, the following cost participation amounts have been determined:

$_____ Co-payment/cost per service **$_____ Maximum family monthly cost share**

FULL FEE OPTION

I have chosen **not** to release my financial information, and therefore, will be billed a maximum of $120 per service up to $960 monthly, which is the maximum cost share per service and maximum monthly cost share amount per family.

Signature of parent / guardian	Date (*month, day, year*)

The family has chosen to fulfill their financial obligation for cost participation of First Steps services in the following manner (*check one*):

☐ Fee for service as listed above ☐ Full Fee option

Signature of parent / guardian	Date (*month, day, year*)

I have informed the parent regarding their rights and responsibilities related to cost participation and have utilized all information provided to me by the family in the estimate of their co-payment.

Signature of intake / ongoing service coordinator	Date (*month, day, year*)

DISTRIBUTION: Original - SPOE, Copy - Service Coordinator and family